

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-007072

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

149

Primary Registration District No. 1002

Registrar's No.

933

STATE FILE NUMBER

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

FILED FEB 26 1963

a. COUNTY Jackson

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN Kansas City

Length of stay in Ib.

3 Mon.

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION General HospitalInside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE KANSAS b. COUNTY WYANDOTTE

c. CITY OR TOWN KANSAS CITY

Inside Limits
Yes ☒ No ☐d. STREET ADDRESS (If outside, give location)
642 BARNETTReside on Farm
Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First Mary

Middle

Last Tagenkamp

4. DATE OF DEATH

Month February 7, 1963

Year

5. SEX Female

6. COLOR OR RACE White

7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday) 79

IF UNDER 1 YEAR: IF UNDER 24 HR.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Work

10b. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (City, and state or country)

UNK

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

UNK

13b. MOTHER'S MAIDEN NAME

UNK

14. NAME OF HUSBAND OR WIFE

NONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Jos. A. Butler's Sons

K.C.K.

18. CAUSE OF DEATH (Enter only one cause of death. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Broncho-pneumonia and marked dehydration

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

2-7-63

to 2-7-63

and last saw her alive on 2-7-63

Death occurred

10:45 P

m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

2400 Cherry

22c. DATE SIGNED

2-8-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

23b. DATE

2-9-63

23c. NAME OF CEMETERY OR CREMATORY

M + CALVARY CEMETERY

23d. LOCATION (City, town, or county)

K.C.K.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Jos. A. Butler's Sons

K.C.K.

25. DATE RECD. BY LOCAL REG.

2-11-63

26. REGISTRAR'S SIGNATURE

Oruth Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Russell W. Henn

Licensed Embalmer No. 3462

P. O. Address K.C.K.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.